VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 13, 2017

Mr. Bill Davidson, Manager
The Residence At Shelburne Bay West
185 Pine Haven Shore Road
Shelburne, VT 05482-7805

Dear Mr. Davidson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 4, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

NOV 01 2017

PRINTED: 10/18/2017
FORM APPROVED

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0589 | A. BUILDING: ______ B. WING ______ | C 10/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE RESIDENCE AT SHELBURNE BAY WEST | 185 PINE HAVEN SHORE ROAD SHELBURNE, VT 05482 |

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| R100 | Initial Comments:<br><br>An unannounced on-site investigation was conducted from 10/2/17 - 10/4/17 by the VT Division of Licensing and Protection. The purpose of the survey was to determine compliance with the Residential Care Home Licensing Regulations regarding facility-reported incidents. The following regulatory violations were identified. | R100 | Initial comments: The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our residents' lives. | |
| R128 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.5 General Care<br><br>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to assure that each resident's medication was administered in accordance with physician orders for 1 applicable resident in the targeted sample. (Resident #3). Findings include:<br><br>1. Per record review on 10/3/17, Resident #3, who experienced agitation with aggressive behaviors, had physician orders for PRN (as needed) Abilify (an antipsychotic medication), 2 mg. tab, 1 tab PO (by mouth) PRN HS (hour of sleep). On 6/29/17, the resident was administered the Abilify, 2 mg. PRN dose at 3:57 PM. A progress note dated 6/29/17, 1604 stated that Resident was having a a small disagreement with another resident (#4) and they were arguing over another person's wheelchair -"Nurse instructed MT (Med Tech - unlicensed staff) to administer PRN Abilify...." | R128 | R128 The action taken to correct the deficiency The nurse involved in the med managment practice which occurred on 6/29/17 has been re-educated regarding the entry of medication orders with special instructions. She has been instructed to review PRN orders before deciding to administer a med. Additionally, she has been educated to check PCC dashboard, daily, to address orders which need follow up. The med tech who was involved has been re-educated surrounding the importance of reading all instructions within an order, and communicating with the nurse.The resident involved suffered no ill effects from the PRN dose of Abilify.<br><br>In order to ensure that the deficient practice does not recur, all nurses will recieve education regarding the requirement listed in 5.5.c. Additionally, the nurses will be educated regarding entry of medication orders, and the daily use of PCC dashboard for order follow up.<br><br>All med techs will be re-educated about the importance of checking orders completely, and communicating necessary information to the nurse. | |

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Davidson — TITLE: Executive Director — (X6) DATE: 11/1/17



R128 - R171 POC's accepted 11/8/17 [illegible] RN/PM

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| R128 | Continued From page 1<br>The resident also had routine orders for Abilify 2.5 mg. PO, 2 times daily (given at 8 AM and 8 PM per the Medication Administration Record (MAR)). The administration of the Abilify at 3:57 PM was not in accordance with the physician orders, as it was documented that the resident was clearly up and moving about the unit and engaging in an argument with another resident. The failure of staff, including the LPN and the MT to adhere to the physician's order was confirmed during interview with the RN Resident Care Director (RCD) on the afternoon of 10/4/17.<br><br>2. Per record review, Resident #3's physician gave orders for a new medication on 4/28/17. The order stated to "Start Memantine 5 mg. PO QD (daily) (for dementia), reassess in 10 days effectiveness and report to MD". The physician later amended the order to say "reassess in 7 days and report to MD". There was no documented evidence in the medical record to indicate that nurses had followed the physician order to reassess the resident and report the results to the MD. The failure to complete the physician order was confirmed during Interview the the RN RCD on the afternoon of 10/4/17. | R128 | The corrective action will be monitored so the deficient practice does not recur. The RCD or designated nurse, will randomly audit a sampling of resident charts at a minimum of twice a year. The audits will include a review of med orders for each resident, with particular focus on orders hich include special instructions (i.e. Give at HS only), or, follow up. | 12/29/17 |
| R153 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.9.c (10)<br><br>Monitor stability of each resident's weight;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the RN failed to ensure that each resident's weight was monitored in accordance with | R153 | R153<br>Action taken to correct the deficiency:<br>The nurse involved in the deficient practice which occurred on 6/4/17 was a travel nurse who is no longer employed by Shelburne Bay. Resident #3 has been reviewed by the RD since 6/4/17. The recommendations remain the same. The resident has suffered no ill effects.<br><br>In order to ensure that the deficient practice does not recur,nurses will recieve education on nutrition and dietary recommendation follow up | |

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| R153 | Continued From page 2<br>recommendations of the Registered Dietician (RD) for 1 applicable resident in the sample. (Resident #3). Findings include:<br><br>Per review of the progress notes for Resident #3, the RD had written on 6/4/17, "Plan - Track weight 2 X per month, add new weight to chart" in response to a weight loss for the resident. There was no follow up to the plan in the medical record and the weight was not recorded 2 X per month as requested by the RD. The omission was confirmed during interview with the RN RCD on the afternoon of 10/4/17. | R153 | requirements. The RCD has reached out to the dietician to coordinate a new system for communicating RD recommendations. The RD will provide a comprehensive report to the RCD and nurses after each RD visit. Nurses will be educated on how to address the recommendations, and how to access the needed recommendations via PCC dashboard.<br><br>The corrective action will be monitored to ensure the deficient practice does not recur. The RCD or designated nurse will randomly audit the RD report against the resident charts to ensure that RD recommendations are followed. The results the audits will be reviewed by QA committee. The The frequency and duration of further audits will be determined by QA committee. | 12/29/17 |
| R160 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following:<br><br>(1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission.<br>(2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.<br>(3) Qualifications of the staff who will be managing medications or administering | R160 | R160<br>The deficient practice occurred with resident #2 who no longer resides at Shelburne Bay.<br><br>In order to ensure that the deficient practice does not recur, the policies and procedures regarding the administration of meds will be reviewed and revised to uphold the requirements listed for 5.10.a. Shelburne Bay will convert to a "bound book" system for tracking, acquisition,storage,disposal, and reconciliation of all narcotic medications. All nurses and med techs will be educated regarding the new system and expectations for practice. All nurses and med techs will recieve annual education on varying topics listed in 5.10.<br><br>The corrective action will be monitored to ensure that the deficient practice does not recur. The system for medication management of controlled substances will be audited by the RCD, designated nurse, or Consultant Pharmacist. Resident charts will be randomly audited for staff compliance with policies and procedures regarding controlled substances. | |

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| R160 | Continued From page 3<br>medications and the home's process for nursing supervision of the staff.<br>(4) How medications shall be obtained for residents including choices of pharmacies.<br>(5) Procedures for documentation of medication administration.<br>(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.<br>(7) Procedures for monitoring side effects of psychoactive medications.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, facility staff failed to administer/assist with controlled medications in accordance with the facility's written policy/procedure for 1 applicable resident in the sample. (Resident #2) This practice had the potential to affect residents receiving controlled medications. Findings include:<br><br>Per review of the Medication Administration Record (MAR) and observation of the "Narcotic Accountability Log" sheets for physician orders for "Ativan, 1/2 tab (0.25 mg) Q 8 hr. as needed for restless agitation, difficult to redirect, unable to engage with staff.", the documentation on the sheets (for Resident #2) was not in accordance with the written policy/procedure, "1.13 ASSISTING WITH CONTROLLED MEDICATION". The Narcotic Accountability log in use for all areas of the facility does not contain all of information to be documented by staff when administering a controlled medication. The current form being used at the time of survey did not include columns to document "amount on hand, amount given, amount received from pharmacy", and staff used the sheets for other | R160 | The results of the audits will be reviewed by the QA committee. The frequency and duration of further audits will be determined by the QA committee. | 12/29/17 |

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| R160 | Continued From page 4<br><br>use including tracking of split tablets of Ativan, then documenting the actual dose administered on a different sheet. During interview (10/4/17) with the RN Resident Care Director (RCD), s/he confirmed that they were not aware of the procedure being used and that it was not in accordance with facility policies. | R160 | | |
| R166 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the RN failed to assure that there was a written alternative method of preparation when medications were administered by staff other than the person who prepared the medication for 1 applicable resident in the sample. (Resident #2). Findings include:<br><br>Per review, Resident #2 had physician orders dated 2/8/17 for "Lorazepam 0.5 mg. tablet, take 1/2 tab (0,25 mg) by mouth every 8 hours PRN agitation" and staff received 0.5 mg. tabs from the pharmacy that were split into 0.25 mg. tabs by the nurse, who then labeled the dose for | R166 | R166<br>The deficient practice for this tag occurred with Resident #2, who no longer resides at Shelburne Bay.<br><br>In order to ensure that the deficient practice does not recur, the policies and procedures regarding the administration of meds will be reviewed and revised to uphold the regulatory requirements listed for 5.10.a. The RCD is working with the Pharmacy to establish a system which will meet the requirement. All nurses and med techs will be educated regarding new, and/or, revised medication policies. Shelburne Bay is committed to upholding the highest applicable standard of practice for medication administration in the AL/RC setting.<br><br>The corrective actions will be monitored to ensure that the deficient practice does not recur. The RCD or designated nurse will perform random audits to ensure that the staff uphold the practices listed in Shelburne Bay policies and procedures. | 12/29/17 |

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| R166 | Continued From page 5<br>administered by other staff. Per review of the facility's medication administration policies and procedures, there was no written process to allow staff to administer medication which they had not prepared themselves. The failure to have a procedure to address this practice was confirmed during interview with the RN RCD on the afternoon of 10/4/17. | R166 | The results of the audits will be reviewed by the QA committee. The frequency and duration of further audits will be determined by the QA committee. | 12/29/17 |
| R171 SS=C | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:<br><br>(1) Documentation that medications were administered as ordered;<br>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;<br>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;<br>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and<br>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.<br>(6) All incidents of medication errors.<br><br>This REQUIREMENT is not met as evidenced | R171 | R171<br>The deficient practice for this tag occurred with Resident #2, who no longer lives at Shelburne Bay.<br><br>In order to ensure that the deficient practice does not recur, Shelburne Bay will review and revise any/all policies and procedures regarding medication management. The updated policies will uphold regulatory requirements listed for 5.10.g. Specifically the policies will reflect documentation for PRN medications, medication errors,monitoring of psychoactive medications, documentation of meds administered as ordered, and, refusals of medications. All nurses and med techs will be educated regarding new or revised polices and procedures. | |

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| R171 | Continued From page 6<br>by:<br>Based on staff interview and record review, the facility failed to establish a procedure for documentation of PRN medications that met the regulatory requirements for VT Residential Care Home Licensing Regulations (RCH) related to PRN medication documentation for 1 applicable resident. (Resident #2). This practice has the potential to affect all residents of the facility receiving PRN medications. Findings include:<br><br>Per record review related to administration of PRN medications, medication technicians (MT) failed to document the effectiveness of the medication and the appropriate reason for use. Per review with the RN RCD on 10/4/17, the electronic MAR for Resident #2 had no follow up documentation of the effectiveness of the PRN medication administered during February, 2017, in the medical record.<br><br>Additionally, per review of the facility policy "P/P 1.12 ASSISTING WITH PRN MEDICATIONS", the policy/procedure directs staff to :<br>"7. One to two hours after giving a PRN medication, document results."<br>When questioned regarding the basis for the directive to wait 1-2 hours before obtaining the resident results/effectiveness of the medication administered, the RN could not provide a professional standard to base the policy on.<br>The failure to have a policy that meets the regulatory requirements for VT RCH homes related to administration of PRN medications was confirmed with the RN on the afternoon of 10/4/17. | R171 | The corrective action will be monitored to ensure that the deficient practice does not recur. The RCD, designated nurse, or Pharmacy Consultant will conduct random audits for reviewing practices related to medication management policies and procedures. The results of the audits will be reviewed by the QA committee. The frequency and duration of further audits will be determined by the QA committee.<br><br>Shelburne Bay will complete all the listed corrective actions by December 29, 2017. | 12/29/17 |